

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029545

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 4448 Primary Registration District No. 6004 Registrar's No. 112

STATE FILE NUMBER

FILED AUG 13 1963

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, give TOWNSHIP only) Lawson		c. CITY OR TOWN Lawson	
Length of stay in lb 11 Years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lawson, Missouri		d. STREET ADDRESS (If outside, give location) 323 N Clark	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Julia Middle Frances Last Denton			4. DATE OF DEATH Month Aug. Day 3 Year 1963		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-18-1876	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Keeping house		11. BIRTHPLACE (City and state or country) Ray, Co. USA	
13a. FATHER'S NAME Fredrick Denton		13b. MOTHER'S MAIDEN NAME Judith Trigg		14. NAME OF HUSBAND OR WIFE Joel R. Denton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address Alva Denton, Lawson, Missouri	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMPHYEMA OF THE GALLBLADDER		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) POSSIBLE GALLSTONE		UNKNOWN
DUE TO (c) POSSIBLE MALIGNANCY OF GALLBLADDER		UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) GENERALIZED ARTERIOSCLEROSIS		
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from FEBR 28-1963 to Aug 2-63 and last saw her alive on AUGUST 2-1963 Death occurred at AUG 3-1963 1.30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Markus Gabriel M.D.	22b. ADDRESS 160 South - EXCELSIOR SPRINGS		22c. DATE SIGNED Aug 6-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-5-1963	23c. NAME OF CEMETERY OR CREMATORY Union	23d. LOCATION (City, town, or county) (State) Lawson Missouri
24. FUNERAL DIRECTOR Jarman Funeral Home, Lawson, Mo.		25. DATE RECD. BY LOCAL REG. 8-9-1963	26. REGISTRAR'S SIGNATURE Mabel Jackson

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 0890

2 0890

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12 90-0

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JAN 28 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lindee Jarman

Licensed Embalmer No. 4589
P. O. Address Excelsior Springs, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.